STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	10/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

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F0000	This visit was for the Investigation of Complaint IN00118286. Complaint IN00118286 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323. Survey dates: October 22-23, 2012 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Survey team: Honey Kuhn, RN Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 8 Medicaid: 64 Other: 10 Total: 82 Sample: 5 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 29, 2012 by Bev Faulkner, RN	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 11/22/12.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interviews, the facility failed to secure the fall mats placed next to resident beds resulting in falls with injury for 2 of 2 residents reviewed for falls. Resident "F" sustained a hip fracture and Resident "D" sustained a scraped shin, lump above the right eye and bloody nose. (Resident "D" and Resident "F") Findings include: 1. The record of Resident "D" was reviewed on 10/22/12 at 12:20 p.m. Resident "D" was admitted to the facility on 05/16/11 with diagnoses including, but not limited to, osteoarthritis, diabetes, depression, hypertension, and cardiovascular disease. Resident "D" had a history of falls. Review of the record for Resident "D" indicated in the nurses progress notes: "09/14/2012 10:45 p.m. Resident found on (sic) sitting on floor next to her bed facing her bed. One end of roommates fall mat was out in middle of room.	F0323	**F323 – Free of Accident/Hazards/Supervision/ Devices** It is the practice of this facility to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident D:* has experienced no further falls and the room was rearranged to keep the pathway clear to the bathroom. *Resident F:* has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident at risk for falls and using a fall mat to prevent injury has the potential to be affected by this finding. A facility audit will be completed reviewing all resident fall care plans and Nurse Aide Assignment Sheets. Any resident	11/22/2012

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	Resident appeared to possibly have tripped on mat....0.5 cm (centimeter) scape (sic) to right shin, small lump noted above right eye, bloody left nostril, 2.5 cm x 0.3 cm bruise to right index finger...." Review of the Fall Investigation indicated: "09/17/2012 10:09 a.m., IDT (Interdisciplinary Team: staff representing different departments to investigate situations/problems) Fall review: Resident experienced an unwitnessed fall on 09/14/12 at approximately 2215. staff (sic) was alerted by bed alarm sounding and observed resident sitting on her buttocks on the floor next to her bed....upon environmental assessment, staff observed that one end of the roommate's fall mat was in the middle of the room. staff (sic) state that resident may have tripped over fall mat....she sustained a a (sic) scrape to the right shin, a lump above the right eye and a nose bleed....environmental safety check completed." Review of the record of Resident"B", the roommate of Resident "D", on 10/23/12 at 12:45 p.m., indicated Resident "B" had a history of falls and a fall mat was to be placed next to her bed.		using a fall mat to prevent injury from falls will have the following: a review by the IDT to determine whether the fall mat is necessary and appropriate for each resident's specific need; a room inspection to determine appropriate arrangement of the floor mat to provide safety and to keep pathways clear; replacement of the current fall mat with one that is appropriately sized and contains a non-slide feature; updates to the Nurse Aide Assignment Sheets and care plans based on any changes or adjustments made. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 11/22/12. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, "Fall Management Program". This in-service will also include review of those residents using a fall mat as an intervention. The importance of proper placement of the floor mat to prevent injuries from falls and to keep pathways clear will also be reviewed. Any resident using a fall mat to prevent injury from falls will have the following: a review by the IDT to determine whether the fall mat is necessary and appropriate for each resident's specific need; a room	

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	2. The record of resident "F" was reviewed on 10/22/12 at 9:30 a.m. Resident "F" was admitted to the facility on 12/16/11 with diagnoses including, but not limited to, CVA (Cerebrovascular Accident: stroke), hypertension, diabetes, and depression. Review of the record for Resident "F" indicated in the nurses progress notes: "09/30/12 8:24 a.m. Res (resident) had an un-witnessed fall at 8:15 p.m., while trying to get up on his own. Alarm was connected but did not sound, Bedside fall mat looked to have been pushed by Res while falling. No visible injuries. Res had c/o (complaint of) pain in L (left) hip....X-ray ordered for L hip. ..." "09/30/12 9:05 p.m. Went to Res's room for 9:00 neuros and found Res attempting to get up alone again..." "10/01/12 3:26 a.m. Residents image results were received, results indicated that resident has a left hip FX (fracture)....resident is being sent to ER...Resident was transported at 12/45 a.m." Review of the Fall Investigation indicated: "10/01/12 9:40 a.m. IDT		inspection to determine appropriate arrangement of the floor mat to provide safety and to keep pathways clear; replacement of the current fall mat with one that is appropriately sized and contains a non-slide feature; updates to the Nurse Aide Assignment Sheets and care plans based on any changes or adjustments made. Continued use of floor mats for specific residents will be determined through the daily clinical meetings and care plan reviews. Changes are communicated to direct care staff promptly through updates to care plans and Nurse Aide Assignment Sheets. The Charge Nurse will be responsible for conducting rounds on all shifts to ensure fall interventions are in place. ***How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure compliance with these corrective actions, the DNS/designee will complete the CQI Audit Tool titled, “Fall Management” daily for 3 weeks, weekly for 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. Proper use and placement of floor mats will be monitored by direct care staff during routine rounds and	

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	(Interdisciplinary Team: staff representing different departments to investigate situations/problems) Fall review: resident (sic) experienced an unwitnessed fall on 09/30/12 at 2012 (8:15 p.m.)...staff noted that resident's fall mat appeared to have slid under his bed during the fall." LPN #4 was interviewed on 10/23/12 at 1:00 p.m. LPN #4 indicated the resident had disabled and bent the bed alarm resulting in it being broken. A review of the MARs (Medication Administration Record), at the time, for Resident "F" indicated the bed alarm had been checked and working at shift change prior to the fall. The DNS (Director Nursing Services) was interviewed on 10/22/12 at 1:00 p.m. The DNS indicated the investigations of falls for Resident "D" and Resident "F" indicated the fall mats being used in the facility were lightweight and able to be folded and moved from the resident's bedside when the residents were in wheelchairs or out of their rooms. The DNS indicated the fall mats appeared to have slid out of place which contributed to both falls. The DNS indicated the IDT identified the fall mat issue following Resident "D"'s fall on 09/14/12, but failed to implement safety measures to prevent further falls from fall mats sliding until		through daily Customer Care Rounds by the IDT. ***By whatdate the systemic changes will be completed:*** Compliance Date: 11/22/12.	

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	the investigation of Resident "F"'s fall. Review of a facility Policy and Procedure, "Fall Management Program: revised 6/12", provided by the DNS on 10/23/12 at 1:30 p.m., indicated: "POLICY: It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental and psychosocial guidelines to prevent injury related to fall. PROCEDURE: Fall risk...Post fall... 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future falls. * The fall event will be reviewed by the team... * The care plan will be reviewed and updated, as necessary 3.1-45(a)(2)			

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